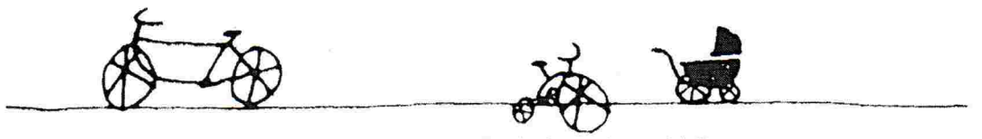

West 11th Street Pediatric Associates, LLP

Genevieve Ferrier, M.D., F.A.A.P.
Lori Rosello, M.D., F.A.A.P.
Alessandra Zullo, M.D., F.A.A.P.
Pamella Brownstein, M.D., F.A.A.P.

Today's Date_____

NEW PATIENT INFORMATION

1. Patient's Name_____
   First Last
   Date of Birth_____ Sex_____ SS#_____
2. Patient's Name_____
   First Last
   Date of Birth_____ Sex_____ SS#_____
3. Patient's Name_____
   First Last
   Date of Birth_____ Sex_____ SS#_____

➢ Address_____ Apt#_____ City_____
State_____ Zip Code_____ Home Phone#_____

❖ Father's/Partner's Name_____
Occupation_____ Work Phone#_____
Cell Phone_____ E-mail_____
Address If Different from Patient's Address_____

❖ Mother's/Partner's Name_____
Occupation_____ Work Phone#_____
Cell Phone_____ E-mail_____
Address If Different from Patient's Address_____

Pharmacy Name_____ Phone#_____
Pharmacy Address (including zip code)_____

Emergency Contact (not parent)_____ relation_____
Cell Phone_____ home phone_____

Insurance Plan_____ Co-pay amount $_____
Policy ID/Member/Subscriber#_____ Group#_____
Primary Insureds's Name_____
Primary Insured's DOB_____ Insured's SSN_____
Secondary insurance Name and policy #_____

I,_____(parent or guardian), have received a copy of West 11th Street Pediatric Associates, LLP's Notice of Privacy Practice.

Financial Policy

Payment for service is required at the time of your child's visit. Payment includes copays and deductibles, balances from prior visits, medical form fees, or payment in full if we do not accept your insurance. (You will be given a receipt to submit to your insurance company if you have out of network coverage).
Initial _____

If you have HMO insurance, it is your responsibility to notify your insurance plan that you have chosen a doctor in our practice to be your child's Primary Care Provider.
Initial_____

It is your responsibility to notify our office of any change in your insurance coverage or contact information. If you fail to do this, all medical service fees will be your responsibility.
Initial_____

I understand that West 11th Street Pediatric Associates, LLP will charge me $50 for any missed appointment that is not cancelled at least 24 hours in advance.
Initial_____

Payment agreement

I/We, the undersigned, do hereby expressly guarantee payment in full and within 30 days of any and all charges for medical services to_____
(child's name)

West 11th Street Pediatric Associates, LLP commencing _____ 20_____.

_____ _____
(parent signature) (parent signature)

_____ _____
(printed name) (printed name)

Credit Card Payment Authorization

We request that your credit card information be kept on file with us. We will mail you a receipt.

_____I authorize automatic use of my card for all outstanding balances, including copays, form fees and deductibles.

_____I authorize automatic use of my card for all outstanding copays and form fees. Please notify me first of any larger charges, such as deductibles.

Name on card: _____

Card name: _____

Card number: _____ Expiration date: _____

Billing address: _____

_____

Signature: _____

NYC Health

NYC Department of Health and Mental Hygiene
Immunization Program
Vaccines For Children Program

ELIGIBILITY SCREENING FORM

Provider Name: _____ **Date of Screening:** ___/___/_____
MM DD YYYY

HEALTH CARE PROVIDER: A record must be kept in the healthcare provider's office that reflects the status of all children up to their 19th birthday who receive immunization through the NYC VFC program. The record may be completed by the **parent, guardian, individual of record, or healthcare provider**. The same record may be used for all subsequent visits as long as the child's health insurance status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

PATIENT INFORMATION:

Child/Patient Date of Birth: ___/___/_____
MM DD YYYY

Child/Patient Last Name	First Name	M.I

Parent/Guardian's Last Name	First Name	M.I

Check the appropriate eligibility category line below for children (up to their 19th birthday) who receive publicly purchased vaccine in New York.

1. Medicaid/Medicaid managed care enrolled _____ Date
2. Uninsured (no insurance) _____ Date
3. Underinsured (insurance does not cover vaccines) _____ Date
4. Native American/Alaskan Native _____ Date
5. Not Eligible (insurance covers immunization) _____ Date
6. Child Health Plus B (CHPlus B) _____ Date

EXPLANATIONS/INSTRUCTIONS FOR USE OF CATEGORIES ON BACK

West 11th Street Pediatric Associates, LLP

46 West 11th Street
New York, NY 10011

HIPPA Consent Form

Effective From.

This consent form allows West 11th Street Pediatric Associates, LLP to use and disclose information about me protected under Health insurance portability and accountability act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

West 11th Street Pediatric Associates, LLP has provided me with a notice of privacy practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing the forming accordance with my right to review its practices before signing consent.

I understand that the terms of notice of privacy practices may change and that I may obtain revised notices by mail or by an update on our website.

I understand that I have right to request, now and in the future, how protected heath information is used or disclosed to carry out treatment, payment and health care operations. I understand that while West 11th Street Pediatric Associates, LLP is not required to agree to my requested restrictions, if does agree, it is bound by that agreement.

I understand that at any time the right to revoke this consent provided that I do so in writing, but that the service may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand the West 11th Street Pediatric Associates, LLP may refuse me further service if I revoke the consent.

Patient's / Guardian's Signature: **Date:**